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M e m o r a n d u m

To: John Black, Administrator
Bakersfield Healthcare Center

Date: May 23, 2011

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On April 28, 2011, the Operation Guardians (OG) team conducted a surprise inspection of Bakersfield Healthcare Center in Bakersfield. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. At approximately 7:45 AM, the team nurse observed Resident 10-06-01 (room 320 B) lying supine with the head of the bed raised approximately 15 degrees. A CNA was questioned about why the resident's head of the bed was flat while he was receiving gastrostomy tube feedings. (The head of the bed must be elevated 30-40 degrees when receiving gastrostomy tube feedings to prevent aspiration). The team nurse then observed the resident's gown was wet. Upon further examination by the CNA, it was determined the resident was saturated with urine. The diaper and bed linen was soaked and the resident's skin was wet from his knees up to his shoulders. The team nurse further inspected the resident's skin and found the gastrostomy tube site was not covered and protected by a gauze dressing. The residens' heels were palpated by the team nurse and determined to be mushy and cool to the touch. According to the National Pressure Ulcer Advisory Panel (NPUAP), this finding suggests a suspected deep tissue injury. Heel protection devices were being utilized on the resident's feet; however, placing a pillow under the calves of both legs so the heels are elevated off the bed has been determined to be more beneficial in preventing further injury than utilizing the heel protectors. The resident was also observed with contractures to his left elbow, bilateral wrists and knees.

   The resident's bed frame, tube feeding pump with the pole and bedside stand were heavily soiled and required immediate deep cleaning. The team nurse asked the nurse supervisor and Director of Nursing (DON) to observe these conditions so that these situations could be resolved, as they were possible instances of resident neglect.

   The nurse's review of the resident's medical record indicated he had suffered a head injury sixteen years ago leaving him with left sided hemiparesis, and aphasia. According to a physician's note, the resident lacked capacity to understand and make decisions. However, during a discussion with a facility certified nursing assistant (CNA), she indicated the resident spoke Spanish and was able to communicate to yes/no answers by blinking his eyes. The CNA was observed communicating with the resident by speaking Spanish and he responded with eye blinking. The resident required nutritional support via gastrosotomy tube and was totally

dependent for all activities of daily living (ADLs). The weight log indicated he had lost eleven pounds in two months and had received wound care treatment for a Stage II pressure ulcer located behind the right ear. The pressure ulcer formation was due to the constant pressure of the nasal cannula positioned around the ear and the lack of nursing assessment and interventions to protect the resident's delicate skin.

After reviewing the Care Plan, Social Services Notes, Physician Notes, Nursing notes and Weekly Summaries, the following additional concerns were identified:

- The Care Plan was not specific for the resident's medical care needs. The plan was "cookie cutter" in appearance with problems and approaches checked off by the licensed nurse with no additional pertinent medical information included.
- It was unclear why the resident was not receiving range of motion exercises. The resident will likely suffer further contractures if range of motion therapy is not implemented. The only RNA program ordered for the resident was for a splint to be placed on the left elbow four hours a day.
- There was no documentation the resident had received dental services since his admission to the facility on January 14, 2011.
- It should be noted a nursing summary dated April 26, 2011 indicated the *"resident is alert and oriented, verbally responsive."*
- The resident was observed in bed during the team inspection and when the DON was questioned why the resident did not get up in a chair she reported the resident "verbally refuses" to get out of bed. It appears that some of the licensed nursing staff did not know the resident was unable to speak.

It is evident after observation of the resident's condition at the bedside, review of the medical documents, nursing documentation and interviews with the facility staff, this resident is not receiving the appropriate quality of care to maintain his current functional status. Additionally, there was no adequate plan of care in place to prevent further medical decline. It was our concern that this resident is being neglected.

2. The Resident in Room 320 C was observed lying in bed and appeared alert. The CNA was preparing to turn the resident and the team nurse requested that she be allowed to inspect the resident's skin for any signs of pressure or breakdown. The CNA reported the resident was capable of notifying the staff when he needed to toilet, however; the resident was observed wearing a diaper. Upon turning the resident a strong fecal odor was detected. During further inspection, it was determined the resident had been lying in liquid stool. The liquid stool was also present on the bed linen. The team nurse observed an area of sanguineous colored fecal matter on the bed linen. The nurse supervisor was requested to come to the resident's bedside to observe the team nurse's findings. The team nurse requested the physician be notified and the appropriate action taken to test the stool for blood. It was apparent from the condition of the resident he had been lying in the feces for some time. This negligent action by the facility staff places the resident at high risk for developing skin breakdown.

3. The medical record review of Resident 10-06-02 indicated that on April 15, 2011 a physician order was received for urine to be collected for a drug screening. Review of the **Nurse's Notes** showed a "**Change In Condition"** document was completed on April 15, 2011 at 1:00 PM indicating the resident was *"lethargic and confused at times. Verbally responsive, ambulating*

with walker, forgetful and drowsy. Resident fell in and out of sleep during conversation with nurse." There was no indication the urine had been collected and sent to the laboratory as ordered by the physician or the reason the urine was being tested for drugs. Also, no documentation was found that the staff continued to monitor the resident for her change in condition.

The next documentation in the **Nurse's Notes** was for April 16, 2011 at 5:45 AM. The note indicated the resident *"slept well, up to bathroom, ambulating in hallway, visited with her friends, no complaints of dizziness, no complaints of pain."*

Nurse's Notes on April 17, 2011, indicated the resident *"appeared more drowsy and was slow to respond to care."* At 9:10 AM, the physician was notified of her change in condition and Emergency Response was notified. The resident was transferred to the emergency room.

A **Physician Progress Note** dated April 18, 2011 indicated the resident was *"sent to the emergency room yesterday secondary to increased creatinine level. She was seen taking extra doses of Paxil and Seraquel."*

On April 25, 2011, an **Interdisciplinary Progress Note** read INCIDENT "IDT" NOTE and indicated the resident was noted to have an increase in lethargy, slurred speech, and was disoriented. She would not eat her meals on April 23, 2011. *"The resident was transferred to the emergency room and the physician and responsible party (resident was self responsible)* were notified." The note further read when the resident exited the facility, her personal items were stored. "*Several pill containers obtained with the patient's private meds, Seroquel 300 mg tablets and Paxil. Unknown how many resident had taken. Incident sheet initiated, Care Plan updated."*

There were no results of the urine drug screen in the resident's chart for review. The DON was questioned for the status of the results and she reported she called the laboratory and they did not have the results available during the OG April 28, 2011 inspection. The laboratory was to FAX a note stating the results were not available to the facility. The team did not receive any type of written communication from the DON during the inspection time. Review of the resident's Care Plan did not include a plan for the resident's alleged overdose of her own medications. It was unclear what plan the facility had implemented to keep the resident safe from further self medicating. It should be noted as of April 25, 201, the resident continued to go out of the facility on pass. It was unclear to the team if the resident had overdosed on her own medications.

4. At approximately 8:10 AM, the resident residing in Room 202 B was observed with the Foley catheter tubing lying in the waste receptacle. Upon further inspection, the Foley catheter bag had approximately 400 cc of yellow urine in the bag. The licensed nurse was questioned by the team nurse as to the facility's policy on draining the resident's catheter bags. The licensed nurse reported the night shift was to empty the urine from the bags. The DON was made aware of the team nurse's findings and she located the output recordings. The DON reported the resident was not on intake and output (I&O) monitoring so the CNA's would not record the urine output. The team nurse voiced the concern that if there were no recordings of output, the facility would be unable to determine if the resident was dehydrated or in renal failure. It was unclear when the last time the resident's catheter bag had been emptied and if the resident was being properly

assessed by the licensed nurses for dehydration.

5. The resident residing in Room 318 B was observed sleeping supine in her bed. Breakfast trays had been passed to the facility residents and it was unclear if this resident had eaten. The team nurse asked the roommate and she knew the resident had not eaten her breakfast because she had to be fed. The team nurse located a CNA and asked if the resident in Room 318 B had been fed her breakfast. The CNA reported "yes." The team nurse requested the CNA locate the resident's tray on the food cart. The food tray was located and observed to be untouched. This was brought to the attention of the DON who ordered the CNA to feed the resident. The team nurse reminded the DON and CNA to reheat the resident's food tray as the food had been sitting for an extended period of time. If the team had not made this observation, it seems this resident would not have had any breakfast.

6. The bedside of the resident residing in Room 318 C was observed with an uncovered pink bedpan sitting on top of the rolling bedside stand. The team nurse questioned if the resident utilized the pan herself and she replied "yes." She acknowledged she could benefit from additional assistance using the bedpan but the call light response time from the nurses was too slow.

   The bedpan was not identified with the resident's name and the manner in which the bedpan was being stored was an infection control issue.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. The lobby of the building contained several brown leather sofas. The sofa's pillows were positioned as though someone had been sleeping on the couch. One of the sofas had protruding buttons on the front of the middle cushion. This could cause skin tears to the fragile elder skin.

2. The draped fabric running along the length of the ceiling of the lobby was filthy with debris that had fallen from the ceiling down onto the fabric.

3. The exit door by the maintenance supervisor's room and room 211 was blocked by facility equipment. Also, the exit door by the Director of Staff Development had equipment stored on both sides of the hall blocking access to the exit. These are violations of the state fire code and potential safety hazards.

4. The clock hanging on the wall in the Mulberry Room was not functioning. The hands of the clock were reading 2:10 when it was actually 8:00 AM and the residents were eating breakfast. This was very confusing for the facility residents. A CNA reported the clock needed batteries.

5. Wheelchairs were observed lined up against the wall in the hallway located by the 200 hallway rooms. One of the wheelchairs held an unmarked pair of shoes, another had a pair of soiled gloves discarded on the seat and a third chair was noted to have a blue catheter bag cover attached to the chair's frame. These are infection control issues.

6. The storage room located by room 319 had supply boxes stored directly on the floor and not on

the pallets as required. The room's exhaust cover did not fit the ceiling fan unit leaving an exposed area around the fan, thus allowing rodents to enter the facility.

7. The residents' rooms contained empty glove boxes housed in holders attached to the walls. This is an infection control issue.

8. The sanitizer hand dispensers attached to the hallway walls were either empty or the units were broken.

9. The oxygen storage room located by Room 316 was observed with debris on the floor. This is an infection control issue.

10. The door to the ice machine room was unlocked and the ice machine was broken. The front of the machine had been removed revealing standing water in the receptacle area of the machine. This is a safety issue for the confused facility residents. The floor of the room was filthy. The facility staff reported the ice machine had been broken for several weeks.

11. The shower room located by Resident Room 106 had feces on the floor of the shower stall, in the drain and on a shower chair that was in the shower stall. The shower curtain was torn off at the hooks. This is an infection control issue.

12. The women's shower room located by Resident Room 207 had feces on the floor of a shower stall and under a shower chair inside another shower stall area. The shower room also contained soiled gloves and soiled linen not properly disposed in containers. The shower curtain was torn off at the hooks. These are infection control issues.

13. The men's shower room located by Resident Room 221 was observed with feces on the floor of a shower stall. The wall soap dispensers were empty and there was an unmarked bottle of liquid bath soap on a shower stall wall. The room had soiled linen on the floor of a shower stall. There was corrosion around the toilet where the bowl met the tile floor, and surrounding the structure of a bath tub unit that housed the mechanical bath chair lift. The plumbing to one of the shower stalls was a safety hazard as the metal extended out from the wall approximately five inches. These are safety and infection control issues.

14. The bathroom between Resident Rooms 214 and 215 had an unmarked water basin and urinal. The bathroom in Room 216 had an unmarked bedpan and debris on the floor. There was an unbearable odor in the room. The bathroom between Rooms 311 and 312 had a <u>used wound dressing</u> on the floor, and a used razor in the trash can. These are safety and infection control issues.

15. The facility's linen was dingy in color, with the appearance of items not being cleaned.

16. The light covers throughout the facility required deep cleaning and/or repairs as they were observed with debris, dead bugs and cracks.

17. The resident rooms were utilizing orange colored extension cords for equipment in constant use. This is a violation of the state fire code.

18. The patio doors that bordered on the inside patio did not lock. This is a resident safety issue.

19. In Room 307 some type of vent was pulling away from the wall. This was a safety issue for residents walking in the room.

20. The hallway on which the 300 rooms were located had a Vector control device that was mounted above head level. An electrical cord coming out of the bottom of the device was loose and just wrapped around the hand rail. This is a safety hazard.

21. Residents were observed with filthy, heavily soiled wheelchairs. Many wheelchair arm rests had cracked vinyl. This could cause skin tears to the fragile elder skin. The facility and residents'equipment was in need of deep cleaning. These are infection control issues.

22. Overall, the condition of the building was deplorable. Resident care areas were flithy, as well as the storage rooms and communal areas. The floors of the facility were observed with ground-in dirt. Baseboards, doors, and walls had chipped paint or nicked painted areas. The residents' furniture, equipment and floors of the residents' rooms were filthy with dried foods and tube feeding formula. Many of the residents' bathroom areas required heavy caulking or replacement of toilets and sinks. The conditions of this building were alarming and posed numerous safety concerns for these elderly residents.

ADMINISTRATIVE OBSERVATIONS:

1. The nurses' stations were messy and chaotic giving the appearance of a dysfunctional and unprofessional nursing facility. The resident charts were stored out of sequence making it difficult to locate a resident's file. Papers and forms were spilling out of cubby slots onto the desk's work area. Pertinent resident information stored in binders at the desks was difficult to locate due to the disorganization. The disorganization of the nurses' desk compromised the nurses' ability to provide quality resident care thus jeopardizing the resident's safety. This lack of organization also compromises the staff's ability to locate a resident's chart quickly in case of an emergency.

2. The facility staff was not wearing name tags. Many of the staff was observed with their name written on a piece of tape applied to their uniforms. This is a violation of Title 22 regulations.

3. The **Monthly Infection Quality Assessment and Assurance Log** for April was viewed. It did not contain the names of Resident 10-06-02 or Resident 10-06-03-- both of whom had been treated for scabies. The log is to be used for surveillance and control of infections.

4. The Operation Guardians (OG) team requested the Weight Review Log for the last six (6) months. The facility DON provided the documents, however; she reported that the documents were not accurate as the scale had not been calibrated until the beginning of April. She was unsure how long the scale had not been accurate or which residents had had significant weight losses or gains in that time period. Inaccurate or missing weights for residents is a serious quality of care issue.

5. Two members of the OG team at approximately 1:30 PM interviewed several residents in their room. The residents' requested that they remain anonymous. The OG team members noted that the room was warm and uncomfortable. One of the residents stated that it had been getting hot in their room even though it was only April. She stated that her daughter had brought in a fan and so far that was helping but she was worried that the hot summer weather would be coming soon. Even in the mild weather, there was a concern about the room's temperature. The same residents reported that it could take up to an hour at night for their call lights to be answered. One resident spoke confidentially to a team member and told her that they did not change her diaper at night because she was told that they didn't have enough diapers to fit her. The resident's roommate expressed concern for her rommate and the fact that she often sat in dirty diapers all night. This could be a possible neglect issue.

6. Review of the facility's "Resident Abuse Investigation Policy and Procedures" showed the facility's policy was not in compliance with California State law. Individuals that witness or suspect abuse or neglect are required to fill out the SOC 341 form, not the Administrator. An individual facility's investigation into possible abuse is completely separate from what is required under California law. Any employee of a facility can be charged with a "failure to report" for failing to follow this law. We would suggest that the administrator and staff review the Department of Justice mandated training materials and video entitled "Your Legal Duty: Reporting Elder and Dependent Adult Abuse."

STAFFING:

Based on the records provided by the facility, staffing levels were above the 3.2 hours per resident day (hprd) on all six of the six days randomly reviewed.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to, Sherry Huntsinger NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 263-1407 or Peggy Osborn at (916) 263-2505.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
May 23, 2011

Bakersfield Healthcare Center
April 28, 2011

I. Summary

During the one-day inspection, numerous examples of deficient care were observed. The chaos in facility operation was apparent, and likely was related to the excessive turnover in administrative personnel during the past 12 months. The numbers of residents transferred to acute care hospitals are excessive, likely because of deficient nursing care in many instances. In this report I will describe findings based on review of 12 residents and on discussion with facility staff and review of other materials on site.

II. Nursing services and processes of care

Review of residents' medical records showed that licensed nurses are not complying with many basic job requirements. In a number of cases, licensed nurses failed to write pertinent information about resident events and changes in the narrative notes; residents were transferred to acute care hospitals with no explanation found in the record. Instances were found of nurses missing physicians' orders, or transcribing orders improperly onto MARs and TARs. Care plans, generic rather than individualized, did not appear to have been utilized by nursing staff in the day-to-day provision of care. Considering the census, the numbers of admissions and re-admissions, and the acuity of the population, it was apparent that nurse staffing has not been sufficient to meet resident's needs.

For example, in one resident's case (Resident 7), an order for the provision of water via gastrostomy tube was confusing and inconsistent with the dietitian's recommendations. However, every nurse on every shift who reviewed the order as written and signed that water was provided failed to notice that the order made no sense, and initialed that the confusing order was complied with. In such cases, for a nurse to document that the order was carried out reflects either that it was not actually carried out, or that the nurse didn't read what it said. The director of nursing services reviewed the record and confirmed my findings. The lack of supervision of direct-care licensed nurses was apparent, as the nonsensical order had been in place for over a month, and spanned two different months. This example is of particular concern because there were a total of 10 residents receiving artificial feeding via tube at the time of our inspection, and the deficient practice posed risks to all of them. Also considering the time-consuming nature of tube-feeding tasks, including ensuring the accuracy of tube feeding orders, the facility needs to provide additional staff and supervision to care properly for so many residents on tube feeding.

In another example, also involving Resident 7, the care plan stated that she was allowed to consume foods by mouth but with "aspiration precautions". Aspiration precautions include positioning the resident upright, feeding slowly in small amounts, and alternating fluids with solids. The resident was observed before and during the lunch meal. Her husband was feeding her in bed; she was not upright, he was not alternating fluids (had not given her any although half the meal was consumed), and she was observed coughing. The care plan present in Resident 7's chart appeared not to have been touched, i.e., the paper was pristine, indicating that nurses were not even reviewing the care plan, as well as not implementing it.

One of the underlying causes for deficient nursing processes is inadequate registered nurse staffing, which was also apparent in the residents' records. Licensed vocational nurses appear to be delivering most of the care, with little evidence of RN supervision. There has also been a turnover of RNs at the facility. LVNs, under their scope of practice, cannot perform resident assessments, they can only gather data, which is one potential explanation for the excessive numbers of hospital transfer. Care planning must be directed by an RN, yet the majority of care plans appeared to have been written by LVNs, again without RN supervision and oversight.

III. Dehydration

Resident 7 became severely dehydrated due in part to the deficient nursing care described above. The resident was receiving water via gastrostomy tube in quantities sufficient for her to maintain normal parameters of hydration status until 3/21/11, at which time the water was cut in half per recommendation of the facility dietitian a month earlier. (During the month that elapsed between the dietitian's recommendation and the documented change, the actual amount the resident was receiving could not be determined because of nursing staff's error in transcribing the water order onto the MAR.) There was no medical rationale for this recommendation; the most recent physician's progress notes did not document any concerns about Resident 7 receiving too much water. Laboratory testing done a week after the water was cut in half shows that Resident 7 was already becoming dehydrated. However, there is no indication that either the physician or the dietitian had been notified of the abnormal lab results. The dietitian's note, written the day the labs were obtained, said nothing about following up the lab results. Three weeks later, Resident 7 was transferred to the hospital because of severe dehydration revealed by laboratory tests that day. The inattention to the water order, the confusing transcription of it, the failure to monitor intake, and the failure to report and follow up abnormal lab results all contributed to this unnecessary event, which clearly harmed the resident and might have led to her death.

IV. Pressure ulcers

The care of one resident with a stage 4 pressure ulcer was reviewed. In my opinion, this wound was *avoidable*. Resident 3 was admitted in December 2010, and per a Braden Scale assessment was not at high risk for the development of pressure ulcers, and did not

have a pressure ulcer on admission. Three weeks later, she had acquired a partial-thickness wound of the sacral area, and within a month the wound was full-thickness. There is no evidence that needed, planned interventions were carried out. While additions were made to her care plan suggesting that the resident was "noncompliant" with pressure relieving interventions, there is no evidence of "noncompliance" until after the wound was noted. Documentation regarding the resident's preference to remain on her back and to remove positioning pillows began showing up regularly in the narrative notes only after the wound had advanced to stage 4. An order for a pressure-relieving mattress was not obtained until after the wound had advanced, and then there was a 1-week delay in obtaining it. There was no assessment of why Resident 3 might have preferred to remain on her back, and no documentation that any efforts were made to gain her compliance.

V. Pain management

One of the reasons Resident 3 might have preferred a certain position was uncontrolled pain. This resident's pain management was not in compliance with accepted standards. Her roommates reported that she screamed when wound treatments were provided, and we observed her in severe pain at the start of wound treatment during the inspection. The resident was receiving hospice care, yet no hospice notes were found in her records, and the orders in place for pain treatment were woefully inadequate.

VI. Physician services

I did see that physicians are visiting their residents timely, however many notes were illegible or devoid of meaningful content. One concern I have is that physicians are ordering residents to the hospital rather than attempting to manage their changes in condition at the facility. Because in many of the transfers reviewed there were no narrative notes referencing the reason for the transfer, it is difficult to evaluate the circumstances. However, when LVNs, unable to complete adequate assessments, phone the doctor with a change in condition, the doctor may have no choice but to transfer. In the case of one resident (Resident 10), he was repeatedly transferred to the hospital despite an advance directive which stated not to. In another case (Resident 9) the advance directive form ("POLST", Physician's Orders for Life Sustaining Treatment) was blank yet signed by the doctor anyway. The whole purpose for the doctor to sign the form it to acknowledge awareness of the directives; signing a blank form is grossly substandard; the physician who signed the blank form was the facility's medical director.

VII. Conclusions

Immediate steps should be taken to correct the many quality of care problems evident at this facility. The new administrator and director of nursing services indicated that they were aware, to some extent, of the problems facing the facility at this time. One important measure likely to produce immediate benefit and strongly recommended is the suspension of any new admissions until quality problems are remedied.